FIRST AID FOR THE®

PSYCHIATRY clerkship

FOURTH EDITION

FOCUSED LEARNING for the psychiatry clerkship

Tips on what to know to IMPRESS ATTENDINGS and EARN HONORS on the shelf exam

Completely UPDATED FOR THE DSM-5

Latha Ganti • Matthew S. Kaufman
Sean M. Blitzstein

Mc Graw Hill Education

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INTRODUCTION

This clinical study aid was designed in the tradition of the First Aid series of books. It is formatted in the same way as the other books in this series; however, a stronger clinical emphasis was placed on its content in relation to psychiatry. You will find that rather than simply preparing you for success on the clerkship exam, this resource will help guide you in the clinical diagnosis and treatment of many problems seen by psychiatrists.

Each of the chapters in this book contains the major topics central to the practice of psychiatry and has been specifically designed for the medical student learning level. It contains information that psychiatry clerks are expected to learn and will ultimately be responsible for on their shelf exams.

The content of the text is organized in the format similar to other texts in the First Aid series. Topics are listed by bold headings, and the "meat" of the topics provides essential information. The outside margins contain mnemonics, diagrams, exam and ward tips, summary or warning statements, and other memory aids. Exam tips are marked by the  icon, tips for the wards by the  icon, and clinical scenarios by the icon.

CHAPTER 1

HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP

The psychiatry clerkship will most likely be very interesting and exciting.

A key to doing well in this clerkship is finding the balance between drawing a firm boundary of professionalism with your patients and creating a relationship of trust and comfort.

Why Spend Time on Psychiatry?

For most, your medical school psychiatry clerkship will encompass the entirety of your formal training in psychiatry during your career in medicine.

Being aware of and understanding the features of mental dysfunction in psychiatric patients will serve you well in recognizing psychiatric symptoms in your patients, regardless of your specialty choice.

While anxiety and depression can worsen the prognosis of patients' other medical conditions, medical illnesses can cause significant psychological stress, often uncovering a previously subclinical psychiatric condition. The stress of extended hospitalizations can strain normal mental and emotional functioning beyond their adaptive reserve, resulting in transient psychiatric symptoms.

Psychotropic medications are frequently prescribed in the general population. Many of these drugs have significant medical side effects and drug interactions. You will become familiar with these during your clerkship and will encounter them in clinical practice regardless of your field of medicine.

Because of the unique opportunity to spend a great deal of time interacting with your patients, the psychiatry clerkship is an excellent time to practice your interview skills and "bedside manner."

How to Behave on the Wards

RESPECT THE PATIENTS

Always maintain professionalism and show the patients respect. Be respectful when discussing cases with your residents and attendings.

RESPECT THE FIELD OF PSYCHIATRY

- Regardless of your interest in psychiatry, take the rotation seriously.
- You may not agree with all the decisions that your residents and attendings make, but it is important for everyone to be on the same page. Be aware of patients who try to split you from your team.
- Dress in a professional, conservative manner.
- Working with psychiatric patients can often be emotionally taxing. Keep yourself healthy.
- Psychiatry is a multidisciplinary field. It would behoove you to continuously communicate with nurses, social workers, and psychologists.
- Address patients formally unless otherwise told.

TAKE RESPONSIBILITY FOR YOUR PATIENTS

Know as much as possible about your patients: their history, psychiatric and medical problems, test results, treatment plan, and prognosis. Keep your intern or resident informed of new developments that they might not be aware of, and ask them for any updates you might not be aware of. Assist the team in developing a plan; speak to consultants and family members. Never deliver bad news to patients or family members without the assistance of your supervising resident or attending.

RESPECT PATIENTS' RIGHTS

1. All patients have the right to have their personal medical information kept private. This means do not discuss the patient's information with family members without that patient's consent, and do not discuss any patient in public areas (e.g., hallways, elevators, cafeterias).
2. All patients have the right to refuse treatment. This means they can refuse treatment by a specific individual (the medical student) or of a specific type (no electroconvulsive therapy). Patients can even refuse lifesaving treatment. The only exceptions to this rule are if the patient is deemed to not have the capacity to make decisions or if the patient is suicidal or homicidal.
3. All patients should be informed of the right to seek advance directives on admission. Often, this is done by the admissions staff or by a social worker. If your patient is chronically ill or has a life-threatening illness, address the subject of advance directives with the assistance of your resident or attending.

VOLUNTEER

Be enthusiastic and self-motivated. Volunteer to help with a procedure or a difficult task. Volunteer to give a 20-minute talk on a topic of your choice, to take additional patients, and to stay late.

BE A TEAM PLAYER

Help other medical students with their tasks; teach them information you have learned. Support your supervising intern or resident whenever possible. Never steal the spotlight or make a fellow medical student look bad.

KEEP PATIENT INFORMATION HANDY

Use a clipboard, notebook, or index cards to keep patient information, including a history and physical, lab, and test results, at hand.

PRESENT PATIENT INFORMATION IN AN ORGANIZED MANNER

Here is a template for the "bullet" presentation:

> **"This is a [age]-year-old [gender] with a history of [major history such as bipolar disorder] who presented on [date] with [major symptoms, such as auditory hallucinations] and was found to have [working diagnosis]. [Tests done] showed [results]. Yesterday, the patient [state important changes, new plan, new tests, new medications]. This morning the**

patient feels [state the patient's words], and the mental status and physical exams are significant for [state major findings]. Plan is [state plan]."

The newly admitted patient generally deserves a longer presentation following the complete history and physical format.

Many patients have extensive histories. The complete history should be present in the admission note, but during ward presentations, the entire history is often too much to absorb. In these cases, it will be very important that you generate a **good summary** that is concise but maintains an accurate picture of the patient.

How to Prepare for the Clerkship (Shelf) Exam

If you have studied the core psychiatric symptoms and illnesses, you will know a great deal about psychiatry. To specifically study for the clerkship or shelf exam, we recommend:

2–3 weeks before exam: Read this entire review book, taking notes.
10 days before exam: Read the notes you took during the rotation and the corresponding review book sections.
5 days before exam: Read this entire review book, concentrating on lists and mnemonics.
2 days before exam: Exercise, eat well, skim the book, and go to bed early.
1 day before exam: Exercise, eat well, review your notes and the mnemonics, and go to bed on time. Do not have any caffeine after 2 PM.

Other helpful studying strategies include:

STUDY WITH FRIENDS

Group studying can be very helpful. Other people may point out areas that you have not studied enough and may help you focus more effectively. If you tend to get distracted by other people in the room, limit this amount to less than half of your study time.

STUDY IN A BRIGHT ROOM

Find the room in your home or library that has the brightest light. This will help prevent you from falling asleep. If you don't have a bright light, obtain a halogen desk lamp or a light that simulates sunlight.

EAT LIGHT, BALANCED MEALS

Make sure your meals are balanced, with lean protein, fruits and vegetables, and fiber. A high-sugar, high-carbohydrate meal will give you an initial burst of energy for 1–2 hours, but then your blood sugar will quickly drop.

TAKE PRACTICE EXAMS

The purpose of practice exams is not just for the content that is contained in the questions, but the process of sitting for several hours and attempting to choose the best answer for each and every question.

POCKET CARDS

The "cards" on the following page contain information that is often helpful in psychiatry practice. We advise that you make a photocopy of these cards, cut them out, and carry them in your coat pocket.

Mental Status Exam

Appearance/Behavior: apparent age, attitude and cooperativeness, eye contact, posture, dress and hygiene, psychomotor status

Speech: rate, rhythm, volume, tone, articulation

Mood: patient's subjective emotional state—depressed, anxious, sad, angry, etc.

Affect: objective emotional expression—euthymic, dysphoric, euphoric, appropriate (to stated mood), labile, full, constricted, flat, etc.

Thought process: logical/linear, circumstantial, tangential, flight of ideas, looseness of association, thought blocking

Thought content: suicidal/homicidal ideation, delusions, preoccupations, hyperreligiosity

Perceptual disturbances: hallucinations, illusions, derealization, depersonalization

Cognition:

Level of consciousness: alert, sleepy, lethargic
Orientation: person, place, date
Attention/concentration: serial 7s, spell "world" backwards

Memory:

Registration: immediate recall of three objects
Short term: recall of objects after 5 minutes
Long term: ask about verifiable personal information

Fund of knowledge: current events

Abstract thought: interpretation of proverbs, analogies

Insight: patient's awareness of his/her illness and need for treatment

Judgment: patient's ability to approach his/her problems in an appropriate manner

Delirium

Characteristics: acute onset, waxing/waning sensorium (worse at night), disorientation, inattention, impaired cognition, disorganized thinking, altered sleep-wake cycle, perceptual disorders (hallucinations, illusions)

(*continued*)

Etiology: drugs (narcotics, benzodiazepines, anticholinergics, TCAs, steroids, diphenhydramine, etc.), EtOH withdrawal, metabolic (cardiac, respiratory, renal, hepatic, endocrine), infection, neurological causes (increased ICP, encephalitis, postictal, stroke)

Investigations:

Routine: CBC, electrolytes, glucose, renal panel, LFTs, TFTs, UA, urine toxicology, CXR, O_2 sat, HIV
Medium-yield: ABG, ECG (silent MI), ionized Ca^{2+}
If above inconclusive: Head CT/MRI, EEG, LP

Management: identify/correct underlying cause, simplify Rx regimen, d/c potentially offensive medications if possible, avoid benzodiazepines (except in EtOH withdrawal), create safe environment, provide reassurance/education, judiciously use antipsychotics for acute agitation

Mini-Mental State Examination (MMSE)

Orientation (10):

What is the [year] [season] [date] [day] [month]? (1 pt. each)
Where are we [state] [county] [town] [hospital] [floor]?

Registration (3): Ask the patient to repeat three unrelated objects (1 pt. each on first attempt). If incomplete on first attempt, repeat up to six times (record # of trials).

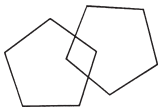
Attention (5): Either serial 7s or "world" backwards (1 pt. for each correct letter or number).

Delayed recall (3): Ask patient to recall the three objects previously named (1 pt. each).

Language (9):

- Name two common objects, e.g., watch, pen (1 pt. each).
- Repeat the following sentence: "No ifs, ands, or buts" (1 pt.).
- Give patient blank paper. "Take it in your right hand, use both hands to fold it in half, and then put it on the floor" (1 pt. for each part correctly executed).
- Have patient read and follow: "Close your eyes" (1 pt.).
- Ask patient to write a sentence. The sentence must contain a subject and a verb; correct grammar and punctuation are not necessary (1 pt.)
- Ask the patient to copy the design. Each figure must have five sides, and two of the angles must intersect (1 pt.).

Mania ("DIG FAST")



Distractibility
Irritable mood/insomnia
Grandiosity
Flight of ideas
Agitation/increase in goal-directed activity
Speedy thoughts/speech
Thoughtlessness: seek pleasure without regard to consequences

Suicide Risk ("SAD PERSONS")

Sex—male
Age >60 years
Depression
Previous attempt
Ethanol/drug abuse
Rational thinking loss
Suicide in family
Organized plan/access
No support
Sickness

Depression ("SIG E. CAPS")

Sleep
Interest
Guilt
Energy
Concentration
Appetite
Psychomotor Δs
Suicidal ideation
- Hopelessness
- Helplessness
- Worthlessness

Drugs of Abuse

Drug	Intoxication	Withdrawal
Alcohol Benzodiazepines	Disinhibition, mood lability, incoordination, slurred speech, ataxia, blackouts (EtOH), respiratory depression	Tremulousness, hypertension, tachycardia, anxiety, psychomotor agitation, nausea, seizures, hallucinations, DTs (EtOH)
Barbiturates	Respiratory depression	Anxiety, seizures, delirium, life-threatening cardiovascular collapse

(*continued*)

Opioids	CNS depression, nausea, vomiting, sedation, decreased pain perception, decreased GI motility, pupil constriction, respiratory depression	Increased sympathetic activity, N/V, diarrhea, diaphoresis, rhinorrhea, piloerection, yawning, stomach cramps, myalgias, arthralgias, restlessness, anxiety, anorexia
Amphetamines Cocaine	Euphoria, increased attention span, aggressiveness, psychomotor agitation, pupil dilatation, hypertension, tachycardia, cardiac arrhythmias, psychosis (paranoia with amphetamines, formication with cocaine)	Post-use "crash": restlessness, headache, hunger, severe depression, irritability, insomnia/ hypersomnia, strong psychological craving
PCP	Belligerence, impulsiveness, psychomotor agitation, vertical/horizontal nystagmus, hyperthermia, tachycardia, ataxia, psychosis, homicidality	May have recurrence of symptoms due to reabsorption in GI tract
LSD	Altered perceptual states (hallucinations, distortions of time and space), elevation of mood, "bad trips" (panic reaction), flashbacks (reexperience of the sensations in absence of drug use)	
Cannabis	Euphoria, anxiety, paranoia, slowed time, social withdrawal, increased appetite, dry mouth, tachycardia, amotivational syndrome	
Nicotine/ Caffeine	Restlessness, insomnia, anxiety, anorexia	Irritability, lethargy, headache, increased appetite, weight gain

Psychiatric Emergencies

Delirium Tremens (DTs):

- Typically within 2–4 days after cessation of EtOH but may occur later.
- Delirium, agitation, fever, autonomic hyperactivity, auditory and visual hallucinations.
- Treat aggressively with benzodiazepines and hydration.

Neuroleptic Malignant Syndrome (NMS):

- Fever, rigidity, autonomic instability, clouding of consciousness, elevated WBC/CPK
- Withhold neuroleptics, hydrate, consider dantrolene and/or bromocriptine
- Idiosyncratic, time-limited reaction

Serotonin Syndrome:

- Precipitated by use of two drugs with serotonin-enhancing properties (e.g., MAOI + SSRI).
- Altered mental status, fever, agitation, tremor, myoclonus, hyperreflexia, ataxia, incoordination, diaphoresis, shivering, diarrhea.
- Discontinue offending agents, benzodiazepines, consider cyproheptadine.

Tyramine Reaction/Hypertensive Crisis:

- Precipitated by ingestion of tyramine containing foods while on MAOIs.
- Hypertension, headache, neck stiffness, sweating, nausea, vomiting, visual problems. Most serious consequences are stroke and possibly death.
- Treat with nitroprusside or phentolamine.

Acute Dystonia:

- Early, sudden onset of muscle spasm: eyes, tongue, jaw, neck; may lead to laryngospasm requiring intubation.
- Treat with benztropine (Cogentin) or diphenhydramine (Benadryl).

Lithium Toxicity:

- May occur at any Li level (usually >1.5).
- Nausea, vomiting, slurred speech, ataxia, incoordination, myoclonus, hyperreflexia, seizures, nephrogenic diabetes insipidus, delirium, coma
- Discontinue Li, hydrate aggressively, consider hemodialysis

Tricyclic Antidepressant (TCA) Toxicity:

- Primarily anticholinergic effects; cardiac conduction disturbances, hypotension, respiratory depression, agitation, hallucinations.
- CNS stimulation, depression, seizures.
- Monitor ECG, activated charcoal, cathartics, supportive treatment.

NOTES

CHAPTER 2

EXAMINATION AND DIAGNOSIS

History and Mental Status Examination

INTERVIEWING

Making the Patient Comfortable

WARDS TIP

The HPI should include information about the current episode, including symptoms, duration, context, stressors, and impairment in function.

The initial interview is of utmost importance to the psychiatrist. With practice, you will develop your own style and learn how to adapt the interview to the individual patient. In general, start the interview by asking open-ended questions and carefully note how the patient responds, as this is critical information for the mental status exam. Consider preparing for the interview by writing down the subheadings of the exam (see Figure 2-1). Find a safe and private area to conduct the interview. Use closed-ended questions to obtain the remaining pertinent information. During the first interview, the psychiatrist

Date and Location:

Identifying Patient Data:

Chief Complaint:

History of Present Illness:

Past Psychiatric History:

First contact:

Diagnosis:

Prior hospitalizations:

Suicide attempts:

Outpatient treatment:

Med trials:

Substance History:

Smoking:

Family Psychiatric History:

Legal History:

Past Medical History:

Allergies:

Current Meds:

Developmental History:

Relationships (children/marital status):

Education:

Work History:

Military History:

Housing:

Income:

Religion:

FIGURE 2-1. Psychiatric history outline.

must establish a meaningful rapport with the patient in order to get accurate and pertinent information. This requires that questions be asked in a quiet, comfortable setting so that the patient is at ease. The patient should feel that the psychiatrist is interested, nonjudgmental, and compassionate. In psychiatry, the history is the most important factor in formulating a diagnosis and treatment plan.

TAKING THE HISTORY

The psychiatric history follows a similar format as the history for other types of patients. It should include the following:

- Identifying data: The patient's name, gender, age, race, marital status, place and type of residence, occupation.
- Chief complaint (use the patient's own words). If called as a consultant, list reason for the consult.
- Sources of information.
- History of present illness (HPI):
  - *The 4 Ps:* The patient's psychosocial and environmental conditions *predisposing to*, *precipitating*, *perpetuating*, and *protecting* against the current episode.
  - The patient's support system (whom the patient lives with, distance and level of contact with friends and relatives).
  - Neurovegetative symptoms (quality of sleep, appetite, energy, psychomotor retardation/activation, concentration).
  - Suicidal ideation/homicidal ideation.
  - How work and relationship have been affected (for most diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition [DSM-5] there is a criterion that specifies that symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning).
  - Psychotic symptoms (e.g., auditory and visual hallucinations).
  - Establish a baseline of mental health:
    - Patient's level of functioning when "well"
    - Goals (outpatient setting)
- Past psychiatric history (include as applicable: history of suicide attempts, history of self-harm [e.g., cutting, burning oneself], information about previous episodes, other psychiatric disorders in remission, medication trials, past psychiatric hospitalizations, current psychiatrist).
- Substance history (history of intravenous drug use, participation in outpatient or inpatient drug rehab programs).
- Medical history (ask specifically about head trauma, seizures, pregnancy status).
- Family psychiatric and medical history (include suicides and treatment response as patient may respond similarly).
- Medications (ask about supplements and over-the-counter medications).
- Allergies: Clarify if it was a true allergy or an adverse drug event (e.g., abdominal pain).
- Developmental history: Achieved developmental milestones on time, friends in school, performance academically.
- Social history: Include income source, employment, education, place of residence, who they live with, number of children, support system, religious affiliation and beliefs, legal history, amount of exercise, history of trauma or abuse.

WARDS TIP

If you are seeing the patient in the ER, make sure to ask how they got to the ER (police, bus, walk-in, family member) and look to see what time they were triaged. For all initial evaluations, ask why the patient is seeking treatment *today* as opposed to any other day.

WARDS TIP

When taking a substance history, remember to ask about caffeine and nicotine use. If a heavy smoker is hospitalized and does not have access to nicotine replacement therapy, nicotine withdrawal may cause anxiety and agitation.

KEY FACT

Importance of asking about OTC use: Nonsteroidal anti-inflammatory drugs (NSAIDs) can ↓ lithium excretion → ↑ lithium concentrations (exceptions may be sulindac and aspirin).

WARDS TIP

Psychomotor retardation, which refers to the slowness of voluntary and involuntary movements, may also be referred to as hypokinesia or bradykinesia. The term akinesia is used in extreme cases where absence of movement is observed.

KEY FACT

Automatisms are spontaneous, involuntary movements that occur during an altered state of consciousness and can range from purposeful to disorganized.

WARDS TIP

A hallmark of pressured speech is that it is usually uninterruptible and the patient is compelled to continue speaking.

KEY FACT

An example of inappropriate affect is a patient's laughing when being told he has a serious illness.

KEY FACT

You can roughly assess a patient's intellectual functioning by utilizing the *proverb interpretation* and *vocabulary* strategies. Proverb interpretation is helpful in assessing whether a patient has difficulty with abstraction. Being able to define a particular vocabulary word correctly and appropriately use it in a sentence reflects a person's intellectual capacity.

WARDS TIP

To assess mood, just ask, "How are you feeling today?" It can also be helpful to have patients rate their stated mood on a scale of 1–10.

WARDS TIP

A patient who is laughing one second and crying the next has a *labile* affect.

WARDS TIP

A patient who giggles while telling you that he set his house on fire and is facing criminal charges has an *inappropriate* affect.

MENTAL STATUS EXAMINATION

This is analogous to performing a physical exam in other areas of medicine. It is the nuts and bolts of the psychiatric exam. It should describe the patient in as much detail as possible. The mental status exam assesses the following:

- Appearance
- Behavior
- Speech
- Mood/Affect
- Thought Process
- Thought Content
- Perceptual Disturbances
- Cognition
- Insight
- Judgment/Impulse Control

The mental status exam tells only about the mental status at that moment; it can change every hour or every day, etc.

Appearance/Behavior

- *Physical appearance:* Gender, age (looks older/younger than stated age), type of clothing, hygiene (including smelling of alcohol, urine, feces), posture, grooming, physical abnormalities, tattoos, body piercings. Take specific notice of the following, which may be clues for possible diagnoses:
  - Pupil size: Drug intoxication/withdrawal.
  - Bruises in hidden areas: ↑ suspicion for abuse.
  - Needle marks/tracks: Drug use.
  - Eroding of tooth enamel: Eating disorders (from vomiting).
  - Superficial cuts on arms: Self-harm.
- *Behavior and psychomotor activity:* Attitude (cooperative, seductive, flattering, charming, eager to please, entitled, controlling, uncooperative, hostile, guarded, critical, antagonistic, childish), mannerisms, tics, eye contact, activity level, psychomotor retardation/activation, akathisia, automatisms, catatonia, choreoathetoid movements, compulsions, dystonias, tremor.

Speech

Rate (pressured, slowed, regular), rhythm (i.e., prosody), articulation (dysarthria, stuttering), accent/dialect, volume/modulation (loudness or softness), tone, long or short latency of speech.

Mood

Mood is the emotion that the patient tells you he feels, often in quotations.

Affect

Affect is an assessment of how the patient's mood appears to the examiner, including the amount and range of emotional expression. It is described with the following dimensions:

- *Type of affect:* Euthymic, euphoric, neutral, dysphoric.
- *Quality/Range* describes the depth and range of the feelings shown. Parameters: flat (none)—blunted (shallow)—constricted (limited)—full (average)—intense (more than normal).
- *Motility* describes how quickly a person appears to shift emotional states. Parameters: sluggish—supple—labile.

- *Appropriateness to content* describes whether the affect is congruent with the subject of conversation or stated mood. Parameters: appropriate—not appropriate.

Thought Process

The patient's form of thinking—how he or she uses language and puts ideas together. It describes whether the patient's thoughts are logical, meaningful, and goal directed. It does not comment on *what* the patient thinks, only *how* the patient expresses his or her thoughts. **Circumstantiality** is when the point of the conversation is eventually reached but with overinclusion of trivial or irrelevant details. Examples of thought disorders include:

- **Tangentiality:** Point of conversation never reached; responses usually in the ballpark.
- **Loosening of associations:** No logical connection from one thought to another.
- **Flight of ideas:** Thoughts change abruptly from one idea to another, usually accompanied by rapid/pressured speech.
- **Neologisms:** Made-up words.
- **Word salad:** Incoherent collection of words.
- **Clang associations:** Word connections due to phonetics rather than actual meaning. "My car is red. I've been in bed. It hurts my head."
- **Thought blocking:** Abrupt cessation of communication before the idea is finished.

Thought Content

Describes the types of ideas expressed by the patient. Examples of disorders:

- **Poverty of thought versus overabundance:** Too few versus too many ideas expressed.
- **Delusions:** Fixed, false beliefs that are not shared by the person's culture and cannot be changed by reasoning. Delusions are classified as bizarre (impossible to be true) or nonbizarre (at least possible).
- **Suicidal and homicidal ideation:** Ask if the patient feels like harming him/herself or others. Identify if the plan is well formulated. Ask if the patient has an intent (i.e., if released right now, would he go and kill himself or harm others?). Ask if the patient has means to kill himself (firearms in the house/multiple prescription bottles).
- **Phobias:** Persistent, irrational fears.
- **Obsessions:** Repetitive, intrusive thoughts.
- **Compulsions:** Repetitive behaviors (usually linked with obsessive thoughts).

Perceptual Disturbances

- *Hallucinations:* Sensory perceptions that occur in the absence of an actual stimulus.
  - Describe the sensory modality: Auditory (most common), visual, taste, olfactory, or tactile.
  - Describe the details (e.g., auditory hallucinations may be ringing, humming, whispers, or voices speaking clear words). Command auditory hallucinations are voices that instruct the patient to do something.
  - Ask if the hallucination is experienced only before falling asleep (hypnagogic hallucination) or upon awakening (hypnopompic hallucination).

WARDS TIP

A patient who remains expressionless and monotone even when discussing extremely sad or happy moments in his life has a *flat* affect.

KEY FACT

Examples of delusions:
- *Grandeur*—belief that one has special powers or is someone important (Jesus, President)
- *Paranoid*—belief that one is being persecuted
- *Reference*—belief that some event is uniquely related to patient (e.g., a TV show character is sending patient messages)
- *Thought broadcasting*—belief that one's thoughts can be heard by others
- *Religious*—conventional beliefs exaggerated (e.g., Jesus talks to me)
- *Somatic*—false belief concerning body image (e.g., I have cancer)

WARDS TIP

The following question can help screen for compulsions: Do you clean, check, or count things on a repetitive basis?

WARDS TIP

An auditory hallucination that instructs a patient to harm himself or others is an important risk factor for suicide or homicide.

- *Illusions:* Inaccurate perception of existing sensory stimuli (e.g., wall appears as if it's moving).
- *Derealization/Depersonalization:* The experience of feeling detached from one's surroundings/mental processes.

Sensorium and Cognition

Sensorium and cognition are assessed in the following ways:

- **Consciousness:** Patient's level of awareness; possible range includes: Alert—drowsy—lethargic—stuporous—coma.
- **Orientation:** To person, place, and time.
- **Calculation:** Ability to add/subtract.
- **Memory:**
  - Immediate (registration)—dependent on attention/concentration and can be tested by asking a patient to repeat several digits or words.
  - Recent (short-term memory)—events within the past few minutes, hours or days.
  - Remote memory (long-term memory).
- **Fund of knowledge:** Level of knowledge in the context of the patient's culture and education (e.g., Who is the president? Who was Picasso?).
- **Attention/Concentration:** Ability to subtract serial 7s from 100 or to spell "world" backwards.
- **Reading/Writing:** Simple sentences (must make sure the patient is literate first).
- **Abstract concepts:** Ability to explain similarities between objects and understand the meaning of simple proverbs.

WARDS TIP

Alcoholic hallucinosis refers to hallucinations (usually auditory, although visual and tactile may occur) that occur either during or after a period of heavy alcohol consumption. Patients usually are aware that these hallucinations are not real. In contrast to delirium tremens (DTs), there is no clouding of sensorium and vital signs are normal.

Insight

Insight is the patient's level of awareness and understanding of his or her problem. Problems with insight include complete denial of illness or blaming it on something else. Insight can be described as full, partial/limited, or none.

Judgment

Judgment is the patient's ability to understand the outcome of his or her actions and use this awareness in decision making. Best determined from information from the HPI and recent behavior (e.g., how a patient was brought to treatment or medication compliance). Judgment can be described as excellent, good, fair, or poor.

Mrs. Gong is a 52-year-old Asian-American woman who arrives at the emergency room reporting that her deceased husband of 25 years told her that he would be waiting for her there. In order to meet him, she drove nonstop for 22 hours from a nearby state. She claims that her husband is a famous preacher and that she, too, has a mission from God. Although she does not specify the details of her mission, she says that she was given the ability to stop time until her mission is completed. She reports experiencing high levels of energy despite not sleeping for 22 hours. She also reports that she has a history of psychiatric hospitalizations but refuses to provide further information.

While obtaining her history you perform a mental status exam. Her **appearance** is that of a woman who looks older than her stated age. She is obese and unkempt. There is no evidence of tattoos or piercings. She has tousled hair and is dressed in a mismatched flowered skirt and

a red T-shirt. Upon her arrival at the emergency room, her **behavior** is demanding, as she insists that you let her husband know that she has arrived. She then becomes irate and proceeds to yell, banging her head against the wall. She screams, "Stop hiding him from me!" She is uncooperative with redirection and is guarded during the remainder of the interview. Her eye contact is poor as she is looking around the room. Her **psychomotor activity** is agitated. Her **speech** is loud and pressured, with a foreign accent.

She reports that her **mood** is "angry," and her **affect** as observed during the interview is labile and irritable.

Her **thought process** includes flight of ideas. Her **thought content** is significant for delusions of grandeur and thought broadcasting, as evidenced by her refusing to answer most questions claiming that you are able to know what she is thinking. She denies suicidal or homicidal ideation. She expresses **disturbances in perception** as she admits to frequent auditory hallucinations of command.

She is uncooperative with formal **cognitive** testing, but you notice that she is oriented to place and person. However, she erroneously states that it is 2005. Her attention and concentration are notably impaired, as she appears distracted and frequently needs questions repeated. Her **insight, judgment, and impulse control** are determined to be poor.

You decide to admit Mrs. Gong to the inpatient psychiatric unit in order to allow for comprehensive diagnostic evaluation, the opportunity to obtain collateral information from her prior hospitalizations, safety monitoring, medical workup for possible reversible causes of her symptoms, and psychopharmacological treatment.

MINI-MENTAL STATE EXAMINATION (MMSE)

The MMSE is a simple, brief test used to assess gross cognitive functioning. See the Cognitive Disorders chapter for detailed description. The areas tested include:

- Orientation (to person, place, and time).
- Memory (immediate—registering three words; and recent—recalling three words 5 minutes later).
- Concentration and attention (serial 7s, spell "world" backwards).
- Language (naming, repetition, comprehension).
- Complex command.
- Visuospatial ability (copy of design).

Interviewing Skills

GENERAL APPROACHES TO TYPES OF PATIENTS

Violent Patient

One should avoid being alone with a potentially violent patient. Inform staff of your whereabouts. Know if there are accessible panic buttons. To assess violence or homicidality, one can simply ask, "Do you feel like you

WARDS TIP

To test ability to abstract, ask:

1. Similarities: How are an apple and orange alike? (Normal answer: "They are fruits." *Concrete* answer: "They are round.")
2. Proverb testing: What is meant by the phrase, "You can't judge a book by its cover?" (Normal answer: "You can't judge people just by how they look." *Concrete* answer: "Books have different covers.")

want to hurt someone or that you might hurt someone?" If the patient expresses imminent threats against friends, family, or others, the doctor should notify potential victims and/or protection agencies when appropriate (Tarasoff rule).

Delusional Patient

Although the psychiatrist should not directly challenge a delusion or insist that it is untrue, he should not imply he believes it either. He should simply acknowledge that he understands the *patient believes* the delusion is true.

Depressed Patient

A depressed patient may be skeptical that he or she can be helped. It is important to offer reassurance that he or she can improve with appropriate therapy. Inquiring about suicidal thoughts is crucial; a feeling of hopelessness, substance use, and/or a history of prior suicide attempts reveal an ↑ risk for suicide. If the patient is actively planning or contemplating suicide, he or she should be hospitalized or otherwise protected.

KEY FACT

A prior history of violence is the most important predictor of future violence.

Diagnosis and Classification

DIAGNOSIS AS PER DSM-5

The American Psychiatric Association uses a criterion-based system for diagnoses. Criteria and codes for each diagnosis are outlined in the DSM-5.

WARDS TIP

In assessing suicidality, do not simply ask, "Do you want to hurt yourself?" because this does not directly address suicidality (he may plan on dying in a painless way). Ask directly about killing self or suicide. If contemplating suicide, ask the patient if he has a plan of how to do it and if he has intent; a detailed plan, intent, and the means to accomplish it suggest a serious threat.

Diagnostic Testing

INTELLIGENCE TESTS

Aspects of intelligence include memory, logical reasoning, ability to assimilate factual knowledge, understanding of abstract concepts, etc.

Intelligence Quotient (IQ)

IQ is a test of intelligence with a mean of 100 and a standard deviation of 15. These scores are adjusted for age. An IQ of 100 signifies that mental age equals chronological age and corresponds to the 50th percentile in intellectual ability for the general population.

Intelligence tests assess cognitive function by evaluating comprehension, fund of knowledge, math skills, vocabulary, picture assembly, and other verbal and performance skills. Two common tests are:

Wechsler Adult Intelligence Scale (WAIS):

- Most common test for ages 16–90.
- Assesses overall intellectual functioning.
- Four index scores: Verbal comprehension, perceptual reasoning, working memory, processing speed.

KEY FACT

The Minnesota Multiphasic Personality Inventory (MMPI) is an objective psychological test that is used to assess a person's personality and identify psychopathologies. The mean score for each scale is 50 and the standard deviation is 10.

Wechsler Intelligence Scale for Children (WISC): Tests intellectual ability in patients ages 6–16.

OBJECTIVE PERSONALITY ASSESSMENT TESTS

These tests are questions with standardized-answer format that can be objectively scored. The following is an example:

Minnesota Multiphasic Personality Inventory (MMPI-2)

- Tests personality for different pathologies and behavioral patterns.
- Most commonly used.

PROJECTIVE (PERSONALITY) ASSESSMENT TESTS

Projective tests have no structured-response format. The tests often ask for interpretation of ambiguous stimuli. Examples are:

Thematic Apperception Test (TAT)

- Test taker creates stories based on pictures of people in various situations.
- Used to evaluate motivations behind behaviors.

Rorschach Test

- Interpretation of inkblots.
- Used to identify thought disorders and defense mechanisms.

WARDS TIP

IQ Chart

Very superior: >130
Superior: 120–129
High average: 110–119
Average: 90–109
Low average: 80–89
Borderline: 70–79
Extremely low (intellectual disability): <70

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